Replaces VHA Directive 10-93-143 and its Supplement

Departments of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 2001-057

September 19, 2001

CORRECTION

HOME RESPIRATORY CARE PROGRAM

1. PURPOSE: This Veterans Health Administration (VHA) Directive establishes responsibility for the administration and management of the Home Respiratory Care Program.

2. POLICY: It is VHA policy that each Department of Veterans Affairs (VA) medical center Director is responsible for the overall administration of the Home Respiratory Care Program.

3. ACTION: Each facility must effect the following lines of responsibility:

a. **Chief, Prosthetic and Sensory Aids Service (PSAS).** The Chief, PSAS, is responsible for the administrative aspects of this program. This includes:

(1) Determining the veteran's eligibility for home respiratory care.

(2) Budget management and control of all Fund Control Points relating to home respiratory care.

(3) Purchase of equipment such as: Continuous Positive Airway Pressure (CPAP) devices, Bi-level Positive Airway Pressure (BiPAP) devices, concentrators, ventilators, nebulizers, etc.

(4) Rental of equipment such as: concentrators, cylinder tanks, liquid reservoirs, ventilators, etc.

(5) Payment for liquid oxygen and cylinder tank fills and refills, and all invoices reflecting charges associated with the home respiratory care program.

(6) Purchase of consumable supplies such as: masks, tubing, disposable nebulizer kits, nasal cannulars, humidification bottles, nasal pillows, etc.

(7) Performance Maintenance Inspections (PMIs) on VA-owned equipment.

(8) Scheduling a minimum of 15 home visits annually, per program, of the patients on home respiratory care. These random home visits are necessary to provide quality assurance of this treatment modality. Individual home visits may be conducted by multi-disciplinary teams consisting of clinicians and prosthetic representatives.

(9) Recording all transactions and expenditures for this program by utilizing the appropriate prosthetic software module, i.e., Home Oxygen Program. Recording home oxygen use as follows: Budget Object Code (BOC) 2574, Cost Center 8272, for rental item, repair, preventative maintenance, cylinder contents or liquid oxygen contents, or other service contract cost; and BOC 2674, Cost Center 8272, for purchasing new items and/or supplies for home oxygen use. Costs associated with clinical respiratory procedures and/or tests done in the home and not identified through PSAS, e.g., not as part of the Home Respiratory Therapy Contract administered by PSAS, requires usage of BOC 2562, Cost Center 8413.

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(10) Contracting process, to include:

(a) Working with the responsible home respiratory care clinician to identify contractual requirements for equipment management such as: concentrators, cylinders, consumable supplies and CPAP devices, ventilators, and other respiratory equipment.

(b) Submission of the home respiratory care contractual requirements to the contracting officer for the development of a solicitation for bids or offers and inspection of bidders' or offerors' facility, prior to award of contract.

(c) Serving as the Contracting Officer's Technical Representative (COTR) for the home respiratory care contract by authorizing the contractor to make delivery and set-up of the appropriately prescribed equipment.

(d) Ensuring compliance with the intent of VHA Directive 2001-006 and related pending publications, including Directives and Handbooks.

(11) Ensurance that all Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards are satisfied by the contractor in accordance with contract requirements, and that such is documented quarterly. ***NOTE:*** *This is often delegated to the Home Respiratory Care Team.*

b. **Chief of Staff.** The Chief of Staff, or designee, is responsible for:

(1) Coordinating efforts of all medical disciplines involved in the treatment of patients who require home respiratory care.

(2) Selecting a Home Respiratory Care Team (HRCT) comprised of the involved medical disciplines and designating the chairperson of the team. The team normally consists of a physician responsible for respiratory care services as the chairperson, a Prosthetic Representative as the coordinator, and a VHA respiratory care practitioner (who may also be the clinical coordinator for home respiratory services). ***NOTE:*** *The team may also include representatives from Pharmacy Service, Nursing Service, Health Administration Service, Pulmonary Medicine Service (or Section), Quality Management, the Home-based Primary Care Program, and the contractor's respiratory care practitioner, as dictated by local needs.*

(3) Reviewing the program on a quarterly basis and advising the HRCT as to any necessary adjustment of team composition or quality assurance initiative changes that may be necessary.

(4) Ensuring that treatment of patients who require home respiratory care meet the clinical guidelines.

c. **Prescribing Clinician.** The prescribing clinician will be responsible for:

(1) Determining the need for home respiratory care based on the patient's prognosis, medical history, and the results of:

(a) Arterial blood gases (ABG's) or pulse oximetry, according to the "Guidelines for Home Oxygen" in the Department of Defense-VHA Clinical Practice Guidelines for Asthma and/or Chronic Obstructive Pulmonary Disease (COPD). ***NOTE:*** *While the guidelines only address the use of oxygen for COPD, exceptions to the criteria may be a clinical condition where it has become practice to try oxygen therapy, i.e., cluster headaches, end stage CHF or other terminal illness. In general, if the patient does not desaturate to the level of 55 PaO_2, even in light of severe dyspnea, supplemental oxygen is not indicated. Physician discretion is to be employed.*

(b) Sleep study.

(c) Effective ventilator settings.

(d) The effectiveness of other interventions.

(2) Ensuring the prescription includes the following general information:

(a) Home oxygen: method of delivery, liter flow or fractional inspiration (F_iO_2) (continuously, on exertion, at night), method of delivery, and duration.

(b) Airway pressure: mask type, settings, spacers, other associated devices.

(c) Ventilator: settings, F_iO_2, mode.

(3) Re-evaluating the patient to ensure the continued need for intervention after the initial re-evaluation (which may be accomplished from 4 weeks to 3 months, depending upon the reason for the intervention). ***NOTE:*** *Veterans requiring long-term oxygen and mechanical ventilation require a re-evaluation annually, at a minimum.*

(4) Notifying PSAS of the continued need or the need to discontinue intervention for each veteran treated in the Home Respiratory Care Program.

d. **Home Respiratory Care Team.** The Home Respiratory Care Team is responsible for:

(1) Reviewing all aspects of the Home Respiratory Care Program in relation to local needs and ensuring the patient receives appropriate care, appropriate home oxygen equipment, and other aspects of the program are available to the patient, as appropriate.

(2) Recommending changes in medical facility policy on home respiratory care.

4. FOLLOW-UP RESPONSIBILITY: Chief Consultant, PSAS Strategic Healthcare Group (113), is responsible for the contents of this Directive. Questions may be addressed to 202-273-8515.

5. REFERENCES: Public Law 104-262.

6. RESCISSION: VHA Directive 10-93-143 and its Supplement are rescinded. This VHA Directive expires September 30, 2006.

S/ Tom Sanders for
Thomas L. Garthwaite, M.D.
Under Secretary for Health

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